Mental Hospitals

NOVEMBER, 1951
Volume 2 Number 9

NEWS BRIEFS OF MENTAL HOSPITAL INSTITUTE. PROCEEDINGS AVAILABLE BY SPRING OF 1952.

Published by
AMERICAN PSYCHIATRIC ASSOCIATION

MEMBERS SUGGEST NEW A.P.A. PROJECTS

At the first discussion of the Institute on Monday morning, the subject was what further steps the A.P.A. could take on behalf of the mental hospitals. The Moderator was Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, Washington, D. C., and chief consultant to M.H.S.

Questions from the floor made it plain that members were deeply interested in the matter of inspection. Dr. Ralph M. Chambers, the Chief Inspector of A.P.A.'s Central Inspection Board, said that so far twelve states, two provinces and the Territory of Hawaii had been thoroughly inspected. This area included forty-two hospitals. Only informal talks had been held so far, he said, about residency training.

Several hospital superintendents said that they had established residencies in general practice, in psychiatry, in gynecology, in internal medicine and in surgery. Others were working to establish residencies in general practice for psychiatric orientation. In New York an elaborate exchange program afforded three year residencies in psychiatry in exchange for neurological services from medical schools and universities. Psychiatric orientation programs on other levels were also well established.

The rating scale was now being prepared and the method submitted to specialists, Dr. Chambers said, and it should be possible to begin giving firm ratings by the end of this year or early in 1952.

Dr. Mesrop A. Tarumianz, Chairman of the Inspection Board, said that the principle of rating had been approved by the A.P.A. and the details were now being worked out. He was particularly anxious to explain that a hospital already approved by the American College of Surgeons would automatically be tentatively approved under the new system.

Dr. J. E. Barrett, Commissioner of Mental Hygiene for Virginia, said that he thought A.P.A. should concentrate upon getting psychiatry accepted by the general medical profession. There was rueful laughter and some applause. Dr. W. E. Barton, Superintendent of Boston State Hospital, said that the relationship had to be recipro-

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Third Mental Hospital Institute Convenes in Kentucky

Nearly two hundred and fifty hospital personnel, including superintendents, clinical directors, psychologists, nurses, social workers and business managers, registered for the Third Mental Hospital Institute held at the Kentucky Hotel, Louisville, Ky., from October 15th through 18th.

Dr. Daniel Blain, Director of the American Psychiatric Association's Mental Hospital Service, keynoted the institute at the opening session on Monday morning, when he explained that the program was entirely informal, with only one prepared paper, that of Dr. Edward Stieglitz of Washington, D. C., on "The Aging Process." For the rest, said Dr. Blain, participation by informal discussion from the floor was the aim of the organizers.

PRESIDENT SPEAKS TO MEMBERS

At the official dinner on Monday evening, the first day of the Institute, the presentation of the six Achievement Awards by Dr. Daniel Blain was followed by an an address to the members by Dr. Leo H. Bartemeier, of Detroit, Mich., president of the American Psychiatric Association. Mr. Barry Bingham, president of the Louisville Courier-Journal, who has appealed editorially for newspapers to drop the word "insane" welcomed the delegates to Louisville.

Dr. Blain presented the first award to Dr. Max E. Witte, Superintendent of Independence (Iowa) State Hospital, for the progress and change of atmosphere in his hospital over a two year period. Dr. John A. Larson of Logansport (Ind.) State Hospital, the second winner, was not present, but Dr. A. M. Gee, of Crease Clinic of Psychological Medicine, Essondale, British Columbia, personally accepted the third award for the establishment of this clinic.

Honorable Mention winners were Dr. Jacob Morganstern, Crownsville (Md.) State Hospital; Dr. John M. Anderson, who received the award on behalf of Topeka (Kans.) State Hospital, and Dr. Cleve C. Odom who represented Arkansas State Hospital, Little Rock, Ark.

Dr. Bartemeier pleaded for the letting down of professional barriers which, he said, did so much to block group action in the field of mental health.

"We, who are primarily interested in human relations must be prepared to relinquish our individual vested interests—professional education, professional training and professional experience—in situations where they make barriers between ourselves and other members of the treatment team," he declared. "Otherwise we are like our own patients, who refuse to give up their symptoms."

It was vital to efface these professional barriers, he continued, in order to work together as a whole. Native qualities of tenderness and patience may often be more important than professional procedures. We should never allow professional training to blind us to the fundamental need—the need to work together for the good of the patient.

Dr. Blain emphasized that discussion was invited from all representatives. While about one-third of the people present were non-medical hospital personnel, there were no laymen present. Everyone was a professional in the field of hospital administration. The maintenance men, engineers, business managers, aides and social workers, as well as the doctors, had something to contribute.

The purpose of the Institute—to enable mental hospital personnel to exchange information and ideas, thus improving the standard of patient care—was implicit in the program of discussions, which ranged from the use of visual aids at different professional levels in mental hospitals to a panel discussion on food preparation and service.

Dr. S. Spafford Ackerly, Chairman of the Louisville Arrangements Committee, welcomed the delegates to the city. He had arranged opportunities for visitors to see outstanding professional installations in the vicinity and regretted that, owing to time limitations, there would probably be no opportunity for them to visit the second oldest mental hospital in the United States —Eastern State Hospital at Lexington, Ky.

INCREASED APPROPRIATIONS A VITAL PROBLEM

"How can mental hospitals justify increased appropriations and charges?" was the vital question debated at the last meeting, conducted by Dr. George W. Jackson, Medical Director of State Hospitals and Schools, Austin, Texas.

Dr. Jackson opened by saying that mental hospitals had real gold for sale. They had more than half the hospital beds in the United States; there were more mental patients than sufferers from cancer, tuberculosis and poliomyelitis combined; for every $2 spent on industrial research, $1 was spent on medical research—yet only 2 cents of this dollar was used for research in mental illness. Salaries both on the professional and other levels in mental hospitals were less than in others, and less than in industry. The question was, how mental hospitals should present their needs to the public—how to share the problem without placing it in the lap of the public and implying criticism of them.

He had asked a Texas legislator, he said, why State Hospitals were always last on the list for appropriations. He was told that it was because they had no lobbies. It was good, said the legislator, to take members of the legislature to see mental hospitals, but superintendents must remember that when it came to voting money, the legislator had to do this on the basis of what the people in his community wanted, rather than upon what he himself had seen. Nobody fought *against* appropriations for any hospitals—on the other hand, nobody fought *for* appropriations for mental hospitals.

Dr. Charles W. Castner, Superintendent of Austin (Texas) State School, said if we could show legislators those who were returned to the community from a mental hospital the people would vote money fast enough.

Informed Citizens Needed

Dr. H. B. Lang, Assistant Commissioner of the N. Y. Dept. of Mental Hygiene Society, said that we did not need a lobby—we needed informed citizens. In New York State, he said, there is a citizens' group which sits in on budget meetings and makes suggestions. This group is appointed by the Governor from various districts to meet with directors of the State institutions and interpret attitudes and needs. These people have direct access to the Governor's office.

Dr. Haydon H. Donahue, Assistant Medical Director, State Board of Hospitals and Schools, Austin, Texas, said good sound public relations was needed for what was after all a billion dollar industry. Mental institutions compete, he said, for personnel, supplies and equipment, with other big industries. We are apt to forget that hospitals are selling something—the care and treatment of patients. The quickest way to sell this is through newspapers and radio. It is not wise to say how bad we are—on the contrary, we must, like all businesses, stress the positive side.

Business men and women's clubs were two of the most influential groups who could and would be helpful if the facts were presented to them properly. Ministers from their pulpits were another potentially useful group.

Watch Your Bill

"Above all, watch your own bill through the legislature," urged Dr. Donahue. "Mistakes can happen—nobody but you has the time or interest to correct what might be a costly error.

"In preparing material for legislators, don't give too many statistics," he went on. "Don't talk about millions of dollars worth of food—talk in terms of cost per patient, per day. The man who has just spent two dollars for his lunch won't be shocked at the idea of spending over fifty cents a day on food for one person. Tell the legislator that the doctor's care per patient is three cents a day—he's just paid a bill to his own doctor for three dollars for one office call!"

This realistic way of presenting costs, said Dr. Donahue, is the most effective with business men, civic groups or legislators.

REVISED STANDARDS DISCUSSED

Dr. Addison M. Duval, St. Elizabeths Hospital, Washington, D. C., and Chairman of the A.P.A. Committee on Standards for Psychiatric Hospitals and Clinics, led the discussion on standards at the second session at the Institute.

The purpose of the meeting was to consider the draft of revised standards as prepared by the Committee, which was based upon the previous published standards.

The basic principle underlying the Committee's work, Dr. Duval pointed out, was good care and treatment for the patient. It was not sound to have low standards, but the committee had felt that the sights should not be set so high as to discourage hospitals which were genuinely working for improvement.

Before the draft was prepared, he went on, more than a hundred hospital administrators were consulted and the result represented the best mature judgment of this group. It was far from perfect but he wished to emphasize that the committee intended only to lay down guide lines, and not to strait-jacket the genius of particular superintendents by over-insistence upon specific recommendations.

From the floor came the interpretation that the revised draft represented the Constitution, while the Central Inspection Board was the Supreme Court which would interpret the spirit of the recommendations in terms of particular hospitals.

These interpretations, said Dr. Duval, would be lenient and no hospital honestly striving for improvement would be penalized or lose its status of "Approved" because of a minor technical violation of the recommendations.

Dr. Neil A. Dayton, Superintendent of Mansfield (Conn.) State School, said that he thought inspections should include Schools for the Retarded which should also receive ratings. If they do not, he said, what do we have to offer to internes and residents? How can we tell what is expected of us?

He went on to suggest that funds for such rating might well be incorporated in the budget of the school or hospital. It would be a fine thing, he said, if the Governor of a state should instigate such inspections—insisting that all mental health institutions comply with the inspection standards of the A.P.A.

The Committee took due note of lively and constructive criticisms from the floor. The draft would be revised, said Dr. Duval, to incorporate certain of these before it was finally presented for approval by the Council and publication by Mental Hospital Service.

The heart and soul of the whole draft, he concluded, was contained in the following Fundamental Principles, which he declared, should constitute the "bible of the mental hospital superintendent."

1. Every hospital or clinic should provide active treatment and humane care for its patients, and educational and research facilities for its staff.

2. The superintendent, manager or director should be a well-qualified physician and an experienced psychiatrist with administrative ability. He should be the chief professional and administrative officer of the hospital, department, or clinic, free from partisan political interference, and should have authority commensurate with his responsibility. He should be administratively responsible only to the appointing authority.

3. The treatment of patients is the primary responsibility of physicians only, and they may not delegate this primary responsibility. Auxiliary professional personnel render necessary and valuable assistance to the physician but this professional activity must remain at all times under the direction and general supervision of the physician.

4. A medical staff of ethical, competent physicians should be provided in sufficient number to furnish effective treatment and care of the patients, with increasing opportunity for individual therapy.

5. Auxiliary professional services should be provided by well trained personnel, adequate in number, properly organized and under competent supervision.

6. Adequate diagnostic, therapeutic and rehabilitation facilities, with efficient technical services under competent medical supervision, should be provided.

7. Accurate and complete medical records should be kept. These should be promptly written and filed so as to be accessible for use in clinical reference and research.

8. Competent personnel should be provided to carry out the necessary administrative and maintenance functions of the hospital.

9. A physical plant should be provided, free from hazards, properly equipped, and with adequate space for the comfort and scientific care of the patients.

10. New mental hospitals should be constructed in locations readily accessible to the population they are intended to serve and preferably in close proximity to medical schools or similar centers of medical activity.

11. Every hospital and clinic should be integrated with the other health resources of the community.

INSTITUTE DELEGATES ATTEND K.A.M.H. DINNER MEETING

Members attending the Institute were welcomed to the first annual dinner meeting of the Kentucky Association for Mental Health, which was held in Louisville on October 17 to coincide with the Mental Hospital Service program.

Dr. Winfred Overholser and Miss Isabel Leighton, author, actress and mental health advocate, were the principal speakers of the evening.

Governor Lawrence Wetherby of Kentucky presented two awards sponsored by the Association. One, a $120 tuition award for advanced psychiatric training, went to a nurse from Central State Hospital, Lakeland, Ky. The second, $50 in cash, was given to the "psychiatric aide of the year in State Mental Hospitals."

The meeting closed with the election of officers and the adoption of a constitution for the newly incorporated Association.

AGING A PSYCHOSOMATIC PROCESS

The only formal paper at the Institute was an address on "The Aging Process" delivered by Dr. Edward J. Stieglitz, one of the country's foremost geriatricians.

Dr. Stieglitz explained the physical and mental aspects involved in aging, and their interrelationship, emphasizing that it is impossible to say what are the results of the "vicissitudes of existence" and what are those of physical changes.

In discussing the physical changes in the aging, Dr. Stieglitz said that there were compensations for the loss of physical prowess. For example, he said, "As we see less clearly we can comprehend more clearly what we do see."

Other somatic factors to be considered were the increased need for iron intake and utilization, greater need of fluids to prevent constipation, the impairment of adaptive mechanisms through chloride loss and the decreased reaction to disease which results in less conspicuous symptoms.

The psychiatric problems, such as memory impairment, "rigid personality" and "second childhood" were often the result of decreased demands being made upon the aging. The saying that "you can't teach an old dog new tricks" only serves to give the elderly an alibi for indolence.

"The responsibility for the prevention or lessening of arteriosclerotic psychoses is that of internal medicine, not of psychiatry," Dr. Stieglitz went on to say. "You have the care of the end result."

However, psychiatry can do much to ward off the psychological traumas—the feeling of uselessness when a man must retire or of the mother's loneliness when the children leave home, and the overdependency on and of parents. ("When should parents leave home?" he asks.)

"These predictable hazards can be foreseen and prevented by education," concluded Dr. Stieglitz. "We can encourage individuals to *grow* old rather than just *become* old."

MENTAL HOSPITALS, a monthly publication, is directed to the staff members of mental hospitals, schools and related institutions who are subscribers to the American Psychiatric Association Mental Hospital Service, 1785 Massachusetts Ave., N. W., Washington 6, D. C. Further details about any item will be supplied on request to staff members of subscribing hospitals. A postcard giving the reference number of the item is sufficient.

Readers are urged to contribute details of ideas successfully developed in their own hospitals for inclusion.

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M.H.S. Regional Representatives: Selected to represent different types of mental hospitals, institutions, and governmental services in all States and Canadian provinces. List available on request.

PSYCHIATRIC FILM PROGRAM AND DISCUSSION

An optional program of psychiatric films and a discussion upon the use of visual film aids at different professional levels in the mental hospital was well attended on Wednesday afternoon and evening.

Directing the program were Dr. George E. Reed, Medical Superintendent of Verdun Protestant Hospital, Montreal, Canada, Dr. A. M. Gee, Director of Mental Hospital Services, Essondale, B. C., Mr. Robert Anderson, producer for the National Film Board of Canada, and Miss Margaret Carter, distribution representative of the Board.

Dr. Reed said that it was often possible for a hospital to produce its own films and make them available to others. He cautioned would-be film makers that it was important to have permission from the patients or their relatives. They must also consider the effect upon the patients.

Dr. Gee, in whose hospital the public education film "Breakdown" was made, said that the filming definitely had psychotherapeutic value to the patients. They enjoyed it and so did the staff.

Mr. Anderson told hospital people that while filmmaking was expensive, it could be done on a small scale. He suggested, however, that a good-sized film is better left to professionals working in close collaboration with the hospital.

The films were good for instructional purposes at all levels; they were good public relations in the community; they were useful to show busy legislators; they were good to show responsible people in other communications media.

Films shown included "Breakdown," a public education film; "Paranoid Conditions," a training film; a U.S. Army film, "Shades of Gray"; a British production, "Out of True"; "Angry Boy," a production of the Michigan Child Guidance Clinic; "Steps of Age," a Canadian Mental Health Film Board Film and a series of seven "Mental Symptoms" training films.

Miss Carter said that the Canadian films were evaluated at the Menninger Clinic before American distribution. Information could be obtained from her office, The Canadian National Film Board, 400 West Madison St., Chicago 8, Ill.

EDITORIAL

The Third Mental Hospital Institute, the biggest and (we hope) the best yet, has come and gone. This issue of Mental Hospitals summarizes the proceedings, especially for the benefit of those who were unable to attend. A full report of the papers and discussions will be published later in book form, as in previous years.

The number of formal addresses was kept to the barest minimum, and the members of the group took part in the discussions freely and enthusiastically. The facilities of the hotel and the hospitality arranged by Drs. Ackerly and Keller and their staffs were in the best Kentucky tradition.

One of the meetings was devoted to a discussion of what further steps the American Psychiatric Association should take in behalf of the hospitals. One point developed was the need for information about hospital plans, construction and equipment. The Mental Hospital Service will attempt to obtain a special grant to enable the compilation of such information for the benefit of the hospitals.

A meeting of 23 of the Regional Representatives was held. They brought out the widespread interest in the Service's film program, and agreed to continue and intensify their search for unusual materials, such as ward procedure manuals, and handbooks for patients' relatives, which can be added to the Mental Hospital Service Loan Library. They urged that personnel at all levels in the hospitals, subject to the Superintendent's review, should be urged to submit information for publication in Mental Hospitals, and conversely that the information contained in the publication should be made available to the various staff departments.

The Regional Representatives will hereafter receive a monthly newsletter, reporting on the Service. We look to them as "roving reporters" to keep Mental Hospital Service informed of developments, trends and needs in the field.

The value of the Institute to the Consultants and Regional Representatives was inestimable in bringing to them the wishes and the needs of those who are charged with the responsibility of operating the mental hospitals of the country. It now seems clear that the Mental Hospital Service and the Institutes have met an urgent need, and that they are here to stay. It should be remembered, however, that the financial support of the hospitals is necessary if the work is to be continued. Those administrators who have not already done so are urged to subscribe to the Mental Hospital Service without delay; only in this way can continuance and further development of the Mental Hospital Service be assured.

WINFRED OVERHOLSER, M. D.,
Chief Consultant

The most effective means of obtaining action from legislative bodies is the publication and maintenance of high standards of care and treatment in mental hospitals.

Dr. Paul Haun, Washington, D. C.
Chief Hospital Consultant,
P & N Division VA.

REASSURING RELATIVES

Thursday morning's second topic was "Techniques for Dealing with Relatives of Patients." The discussion leader, Dr. Edward N. Pleasants, Superintendent of Raleigh (N. C.) State Hospital, pointed out that such techniques would vary according to the hospital location, the extent of the area served, and the cultural and social background of the region.

It was emphasized that the relatives of a mentally ill patient need consolation, reassurance and hopefulness. These should be extended on a realistic basis. Taking time to correct misapprehensions will go far to bring about a truer realization of the nature of mental disorders. In many hospitals this is accomplished by the social worker or the chaplain at the time of admission.

At Raleigh a pre-admission letter and questionnaire on the patient's history is sent to the relative who will accompany the patient. This gives the relative some idea of the type of information he will be expected to give. The hospital has found that it does not deter relatives from accompanying the patient to the hospital.

The hospital also employs several valuable post-admission procedures. A letter is sent to the committing physician giving him the details of the patient's condition upon admission and the results of staff discussions of the case. The hospital chaplain writes a pastor-to-pastor letter to the patient's minister. In it he invites him to visit the patient. These messages are relayed to the patient's family, and provide further reassurance that the hospital is interested in the patient's welfare as an individual.

In dealing with the parents of mentally defective children, one superintendent said his hospital has found that it helps to relieve the parents' feelings to inspect the hospital facilities before they decide to commit their child. He explains to them what the hospital can accomplish and what it cannot. One state school sends out a monthly newsletter to parents which has resulted in fewer inquiries and more active participation in school events, such as sponsoring birthday parties for their child.

Autopsy Permits

The problem of obtaining autopsy permits was helped at one hospital by gaining permission through the committing physician, rather than asking the relatives directly. That hospital now has a 25% autopsy rate, as compared to a previous zero rating. The relatives are informed of the findings and thanked for granting their permission.

Relatives and Ward Personnel

Mr. Paul Harris III, head of the Psychiatric Aide Section of the National Association for Mental Health, noted that the relationship between relatives and on-the-ward personnel must not be overlooked—that the nurses and aides should be given sufficient information regarding the patients in their care in order to answer relatives' inquiries satisfactorily.

Mr. Harris, a former psychiatric aide himself, also said that the practice of "slipping the aide a little extra" can be discouraged by letting relatives know that no "little extra" is necessary to insure the best possible care. Regarding the more insistent "tippers," Mr. Harris says, "Some aides deal realistically with the situation by putting the money into the patient's account." Thus, indirectly, the worried relative realizes that the same integrity will be applied to the care of his patient.

GROUP METHODS IN HOSPITALS

The moderator of this program was Dr. Elvin V. Semrad, Clinical Director of Boston State Hospital. Dr. Semrad said that since he was discussing group methods he would himself call upon group support, and had therefore invited Dr. Crawford N. Baganz, Dr. D. F. Moore and Dr. Bernard A. Cruvant to take part in the discussion with him.

At Boston, said Dr. Semrad, the group process itself is used for training purposes and staff conferences are held at the service level.

As far as group work with patients was concerned, it undoubtedly raised administrative problems. The administrator must set up the method for proper evaluation. This involved personnel, time and money.

Dr. Baganz, V.A. Hospital, Lyons, N. J., said that his hospital too used group meetings with staff on all levels. The administration had learned a lot from these.

Dr. Cruvant, Senior Medical Officer, St. Elizabeths Hospital, Washington, D. C., said it was a common delusion that a group therapy program was a number of ill people together with one person not so ill as the leader. It was not so—groups must be carefully structured. It was not possible to carry over the techniques of individual therapy—the group itself was an instrument.

The separation of administrative decisions from therapy was essential. Otherwise patients frequently took the opportunity to "air a gripe" rather than to examine carefully the nature of their own difficulties.

Dr. Moore, of the VA Hospital, Louisville, Ky., said that group therapy, once started to save time, had now become an integral part of treatment.

His conclusions, from his own experience, were that group therapy could not stand alone. Almost an equivalent amount of time was required for individual therapy to deal with the problems raised in the patient's mind during group work. Secondly, he thought that an evaluation was important, as soon as possible after the group was finished. For this purpose, he liked to use another staff member as a second observer.

A question was raised regarding the hospital which was short of personnel and yet wanted to do group therapy. It was thought that provided the psychiatrist took full responsibility and guided the work carefully, a non-medical member of the treatment team, such as a social worker, aide or nurse, might be trained to do this work. But the administrator must not expect too much.

The reason why group work was sometimes quite successful with non-medical leaders was because any human contact was better than none for the patient. Dr. Cruvant thought that as many get well "apparently" without treatment, it might be because they had been able to build a constructive relationship with an aide, a nurse or even another patient.

It was sometimes possible therefore, to employ what might be called "indirect group therapy" when staff was limited. By concentrating upon the psychological difficulties of staff members in dealing with patients, it could be made possible for them to make better patient contacts, thus increasing the incidence of apparently "spontaneous" recoveries.

AWARDS PRESENTED AT THIRD MENTAL HOSPITAL INSTITUTE

Achievement Award winners smile as Dr. Daniel Blain, MHS Director, congratulates Dr. Max E. Witte, Superintendent of Independence (Iowa) State Hospital, holding his certificate for the First Award.

L. to R.: Dr. Cleve C. Odom, Arkansas State Hospital, Little Rock, and Dr. George W. Jackson; Dr. Jacob Morganstern, Superintendent of Crownsville (Md.) State Hospital; Dr. A. M. Gee, Crease Clinic of Psychological Medicine, British Columbia; Dr. Witte; Dr. Blain and Dr. John M. Anderson, Topeka (Kansas) State Hospital.

SCHOOL AND BOARDING HOME CARE DISCUSSED

Standards for schools for the mentally deficient and homes for boarding care were discussed at one of the Tuesday morning simultaneous sessions under the chairmanship of Dr. Neil A. Dayton, Superintendent of Mansfield (Conn.) State Training School and Hospital.

Dr. Dayton passed out copies of the guiding principles in use in his hospital for field workers investigating private boarding homes for retarded patients. Included in the draft were regulations for the boarding home mother. *Copies may be obtained from M.H.S. on request, by courtesy of Dr. Dayton.*

All participants agreed that the basic administative difficulties of the schools did not differ in essence from those of mental hospitals, and it was emphasized that schools too should be judged by the A.P.A. standards or their equivalent. The hope was expressed that A.P.A. would take up this project, and put inspection of schools into operation.

Dr. Gale H. Walker, Superintendent of Polk State School and Consultant to M.H.S., said that he found a good deal of pessimism among schools. They were sometimes considered by professional men to be a rather static field. This was the main difficulty in getting staff.

Research was very much indicated, said Dr. Francis H. Sleeper, Superintendent of Augusta (Me.) State Hospital, and added that he personally had been thrilled and encouraged to see the really beautiful care these children usually get.

Mrs. Anna T. Scruggs, Superintendent of Enid (Okla.) State School, said that the function of the school was not only to care for and educate the children, but also make their families happy and contented and to give them hope. Dr. Dayton interjected that he agreed and that he did not think the job could be properly done until each superintendent of each school had talked personally with everybody in his state to educate them to the need for more money and more public interest.

Mr. Theodore Bravos, Business Manager of Sonoma State Home in California, gave details of their new buildings and clinical programs and offered help and exchange of information to other schools who wished to get in touch with him. He has also promised M.H.S. source material for distribution to other interested members.

Several members stressed the value of Parents' Groups. These served a double function in some cases—the school was able to use the parents as voluntary recreational aides, and the feelings of the mother were assuaged by this form of service. The one rule in his hospital, said Dr. Charles K. Bush, of Dixon (Ill.) State Hospital, was that a mother was not permitted to work in the same age group with her own child.

DISCUSSION OUTLINES OF OTHER SIMULTANEOUS SESSIONS

Other simultanous sessions included discussions on Economy in the Small Hospital; Hospital-University Relationships; Ward Management; and The Sexual Psychopath. Moderators gave a brief summing up to a plenary session after the individual meetings were over.

Small Hospital Economy

Utilization of personnel had to be the major emphasis when the question of economy was raised, said Dr. G. Wilse Robinson, Jr., co-Medical Director of the Neurological Hospital in Kansas City, Mo., who acted as moderator.

The small hospitals were generally typed as (1) rapid-treatment, (2) treatment of chronic cases and (3) custodial care of elderly patients. The major function of any small hospital determines into which of those categories it fits, and personnel must be utilized accordingly. The rapid-treatment hospital, for instance, has less use for a recreational or occupational therapist than do the other types.

No economy can be made, however, on the salaries of necessary personnel. This raises a problem since the income of the small hospital is subject to wide variation. At one small hospital a bonus plan has worked satisfactorily.

The consensus of the group was that since the functions of hospitals differed to such an extent that the personnel requirements varied, any set of standards devised for the small private psychiatric hospital would have to make allowances for these variations.

Hospital-University Relationships

Dr. R. A. Chittick, Superintendent, Vermont State Hospital. Waterbury, told the plenary session that long distances between a hospital and a university were not insuperable barriers to an active program.

He said that the meeting had decided that if state legislatures could be persuaded to grant appropriations for this type of program it would save State money in the long run because of the improved standard of patient care which would result, with consequently shorter periods of hospitalization. The programs did not necessarily have to be large.

Dr. Daniel Blain said it had been suggested that the A.P.A. might find out the cost of a reasonable sized training program of this type, and that if others thought this idea useful, his office would undertake the project. He asked members to write in if they thought this would be helpful to them.

Dr. Blain also told the group that the Governors' Conference in September, 1951, had requested the Council of State Governments to make a study and interim report with respect to the ways in which the states might work toward the prevention and quick cure of mental illness. This study was to include:

1. A survey of methods of training personnel and conducting research into the causes, prevention and cure of mental illness.
2. An investigation into the possibility of setting up in less populous areas, regional mental health bodies which could pool the training resources and research of a number of states in the common fight against mental illness.
3. An inquiry into the possibility of an overall method whereby states could plan and coordinate their research & training programs toward preventing mental illness and reducing the population of mental institutions.

Dr. Blain said, however, that it was not yet decided how this work would be carried out.

Specific fields in which the university-hospital programs had been found useful were nursing; social work; psychology; physical training and recreational programs with P.T. students, and occupational therapy. One university had offered academic training to its affiliate hospital's employees; the hospital provided the space—the unisity did the rest.

Ward Management

Dr. L. P. O'Donnell, Director of Harlem Valley (N. Y.) State Hospital, deputized ably as discussion leader on this subject for Dr. Harry Worthing of West Brentwood, N. Y., who was unable to attend.

The discussion, said Dr. O'Donnell, was limited to how to deal with the patient.

Aides held up a mirror to the psychiatrist in his relations with ward and ward personnel; they declared that even if a doctor's orders were carried out faithfully, there was some uneasiness communicated to the patients if the aide himself was not fully satisfied with the wisdom or the reason for the order; more interpretation from the psychiatrist was indicated. Then, too, doctors frequently gave orders to the wrong person, with the result that the order went astray.

Lack of consideration in the timing of orders for specific procedures often reacts unfortunately upon ward aides and therefore upon patients; an order for treatment which will interfere with meal times adds to the patient's discomfort.

The dull hours after supper in a ward were also discussed. It was hard to ask the recreation people to come back to take care of these hours, but if the aides themselves could be instructed a little in recreational or even occupational therapy programs, they could carry on during those after-supper hours, so that patients would not have to sit idly till bed time. A simple thing like ceiling lights which do not enable patients to read or work in comfort can, if remedied, add greatly to better patient care and comfort.

Sexual Psychopathy

The emotional charge this subject has, not only for the public but also for the profession, was reflected in the large attendance at this discussion, said Dr. Raymond D. Waggoner, Director, Neurological Institute of the University of Michigan, Ann Arbor, in summing up the meeting.

He pointed out that the emotional reaction on the part of the public makes sex crimes seem more of a problem than they really are.

"After all, the victim of an automobile accident is just as dead as the victim of a sexual psychopath," he declared.

Dr. Waggoner, who is a member of the Michigan Governor's Study Committee on Sexual Deviants, said that the law is beginning to recognize that sexual psychopathy is a borderline matter and that the condition is not a clinical entity but a symptom of other disorders. The sexual offender might not be psychopathic, but pre-psychotic or a compulsive neurotic. No real definition is yet possible, but this recognition by the law in many states is a step towards the solution of the problem.

"Sexual deviation is, of course, a symptom of a more basic personality disorder," he went on. "Intensive psychotherapy is the best answer we have so far."

Dr. Alexander Simon, Assistant Medical Superintendent of Langley Porter Clinic, San Francisco, described some biochemical research which is being carried out in California.

During the past three years one state has castrated over 150 people, but this is no solution to the problem. Castration doesn't reduce the ability to have sexual intercourse.

In Michigan a recommendation has been

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Aide Training Trends

The discussion on "Programs in Selecting and Training Ward Personnel" was opened with a report by Dr. Juul C. Nielsen, Director of the Indiana Mental Health Council, on a psychiatric aide workshop held recently.

The workshop was concerned with the role of the aide in fulfilling the needs of the patient. Dr. Nielsen emphasized that it did not aim to establish any standards of selection or training, or develop any curriculum, or specify any duties of the attendant.

He related that there are 604.286 patients in public mental hospitals. To care for these are 9,314 nurses in psychiatric facilities, 3,677 of whom do ward duty. Of these, only 1,222 are in state hospitals. There are 81,382 attendants working in public mental hospitals, only a small percentage of whom have had any training.

"It is evident," Dr. Nielsen said, "that the burden of patient care rests with the attendant."

At the workshop the attendant was termed as "the person who is a very important individual, if not *the* most important one, in the psychiatric team because he works continually with and for the patient in his process toward recovery and his ultimate return to society as a useful citizen. The attendant is the person on the hospital staff who has the most contact with the patient and who exerts the major influence upon him, either constructively or destructively."

The workshop stressed that any program should aim to assist the attendant to become more effective in his work towards patient recovery; that the needs of the patient receive first consideration, and that these needs also determine the function of the attendant. "It was the consensus," Dr. Nielsen said, "that more important than didactic lectures was the development of a wholesome relationship with the patient in building attitudes conducive to recovery."

Selecting Aide Trainees

As a criterion for selection of a trainee such qualifications were mentioned as: "A literate heart," "Somebody that can give more than their hands," and "A reasonable level of educability."

"It was stated," Dr. Nielsen said, "that such training was not to create a new profession, but a better one; nor to displace the registered nurse—the work of the attendant and the registered nurse are complementary to each other in patient care. With the scarcity of trained psychiatric nurses and a limited recruitment possibility we can never expect the nurse to cope with all patient care."

Justifying The Cost

The discussion that followed Dr. Nielsen's report disclosed that aide training programs were too new to know what effect they have on recovery rates.

Miss Elsie C. Ogilvie, APA Nursing Consultant, said that the cost of turnover of untrained ward attendants should be studied as well as the results of training.

Titles For The Trained

It was mentioned that trained attendants are called "Psychiatric Technicians" in New Jersey and California. Incidentally, in six years the New Jersey program has produced 375 graduates. Three hundred of these are

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RESEARCH IN THE MENTAL HOSPITAL

Dr. D. Louis Steinberg, Supt. of Elgin (Ill.) State Hospital, was the discussion leader of this Tuesday afternoon group.

Points emphasized were that research cannot be a part time avocation like bridge or golf. It must be undertaken by a man with his body and mind both fresh.

Nor was it possible to define the area of research and then find someone and tell him to do it. The hospital must have someone with "a curiosity" and give him his chance. The researcher must have time, space and materials—all of which imply funds. It was not difficult, however, to get support for clinical research. Basic research was a little more difficult.

"The battle against overcrowding was long ago lost—but we must carry it on because we cannot withdraw with honor," said Dr. Alfred P. Bay, Superintendent of Manteno (Ill.) State Hospital. "But we can and must divert many of our energies and money into research to have better weapons finally to fight this old battle."

Dr. G. Wilse Robinson, Jr., of the Neurological Hospital, Kansas City, Mo., and Dr. Walter E. Barton of Boston (Mass.) State Hospital, both said that given curiosity, persistence and enthusiasm, it was possible to uncover much valuable material even when the hospital could not afford a full time program. There might be many dead ends, but something might come of it, and frequently does.

"Good research," said Dr. Barton, "begins with a sensible question which you ask and to which you can find no answer."

Dr. Barton's policy statement, circulated in his own hospital upon "Research—Principles and Protocol" has been made available to MHS and will be sent out as a supplementary mailing within the next few weeks. It is a practical document, which defines the proper way of setting up a research project in a hospital and includes details upon controls, the use of statistics, the preparation of a protocol, preliminary consultation, publication and references.

Pyschodrama Presentation

(*For this interesting professional report upon the Psychodrama Demonstration held at Louisville, Ky., at the VA Hospital, MENTAL HOSPITALS is indebted to the doctor who kindly agreed to undertake this work. He feels, however, that as it is "merely a report or an impression" it should remain unsigned.*)

About ninety members of the Third Mental Hospital Institute and an equal number of invited staff members and guests witnessed the technique of psychodrama Wednesday afternoon under the direction of Dr. and Mrs. Jacob Moreno, of Beacon, N. Y., in the recreation hall of the VA Hospital, Louisville, Ky.

Prior to his presentation Dr. Moreno explained that in the total therapeutic situation all hospital employees must participate. In fact, group psychotherapy in its present form is the only preliminary effort and form to the complete mobilization of all the persons of the institution who are oriented to serving the mental patient. Group psychotherapy is the beginning and terminal force in the therapeutic society of of the total hospital situation which includes all the other general or specific therapies.

Psychodrama is only one of the techniques used and represents an action method for changing the patient's behavior. It furnishes a common point of reference for all the therapeutic efforts made toward the common goal of changing his habit patterns for good mental health. To do this one must create situations directly concerning the patient and his individual experience. The patient himself gives clues by portraying how he feels and acts in the situation enacted. He "feels" his way back to reality at the same time that the therapist "feels" his way into the patient's attitudes.

Psychodrama is an analytical procedure through dramatized sessions whereby a group structure is built about the patient giving the therapist a medium for exploring his interpersonal relationships.

With the assistance of Mrs. Moreno, the doctor presented his techniques of psychodrama using several volunteer patients from the VA hospital and drawing upon the audience for substitute roles in the enactment of scenes in a patient's past life. The material was unrehearsed and the patients had not been previously seen. The development of psychodramatic action was shown in its natural evolution and various special techniques were explained.

Psychodrama was offered as a method of prevention as well as of better appreciation of mental illness. By intimate contact in displaying the traumatic situation the patient recalls more vividly the events on a conscious level. By repeated sessions he then works out changes in his feelings and actions for healthier living. Dr. Moreno used interpolation of character roles freely giving the patient full opportunity to build up his group situation.

INTENSIVE TREATMENT A THERAPEUTIC ATTITUDE

In a lively discussion, under the chairmanship of Dr. Alexander Simon, Assistant Medical Superintendent, Langley Porter Clinic, San Francisco, Calif., upon the operation of intensive treatment centers, the sense of the meeting was that therapeutic attitude was the most vital constituent.

Techniques, however advanced, were not likely to be effective without this therapeutic attitude and feeling of optimism, said Miss Mary E. Corcoran, Nursing Consultant to the National Institute of Mental Health, Bethesda, Md.

A feeling of optimism in an intensive treatment program was not necessarily unrealistic, stressed Dr. Simon. Improvement can and does occur and it is up to the entire treatment team to try and make this improvement possible.

Dr. Paul Haun, Chief Hospital Consultant, in the P & N Division of VA Central Office, Washington, D. C., said that the goals in hospital care were dual—to treat and to restore. We should not regard patients whom we must keep as therapeutic failures. It was a question of maintaining some patients at the highest possible level of hospital adjustment and it was in this goal that intensive therapy was so frequently successful.

Dr. Cecil L. Wittson, Director, Nebraska

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Food—Therapeutic Aid and Administrative Problem

"Food can be an important therapeutic measure for rehabilitation of the mental patient" was the keynote of a panel discussion on Food Preparation and Service. The panel included Mrs. Cora M. Kusner, Chief Dietitian of the Colorado State Hospital at Pueblo; Miss Lavern Owens, Food Administrator, California Dept. of Mental Hygiene; Dr. Francis H. Sleeper, Superintendent of Augusta (Me.) State Hospital, and was led by Dr. Ralph M. Chambers, Chief Inspector of the A.P.A. Central Inspection Board.

Mrs. Kusner discussed dietary organization and menu planning. She said that the first requisite of anyone in charge of food service in a psychiatric hospital ought to be sincere interest in the patients' welfare; second, a sound knowledge of nutrition, and third, administrative ability to organize food production, train employees, and maintain high food standards. Ideally, she has a voice in establishing standards of quality and quantity of food both purchased and produced; she originates plans for equipment of proper design and sufficient quantity; and she institutes training programs for kitchen employees to enable them to carry out her program.

"However," she warned, "these are rather sweeping statements. No such program will be achieved in a year."

The dietitian needs the support and assurance of the hospital administrator in maintaining food standards. "Personally," she added, "I think that if psychiatric hospitals could just forget the word 'psychiatric' and remember that they are hospitals, as far as food is concerned, half the battle would be won."

Menu Planning

Mrs. Kusner, who speaks from twenty-seven years of dietary service, has found that a single menu *pattern* may suffice for many groups, but the actual menu has to be tailor-made on the job. It must be fitted to the supplies on hand, the equipment available, and the skill and number of cooks to prepare it.

Therapeutic diets, always a problem, can best be handled by a dietary unit especially equipped for the purpose, she says. In a psychiatric hospital, a medical and surgical unit needs all of the diet variations used in a general hospital.

Mrs. Kusner concluded:

"Let's be realistic about the situation—anyone can dream up menus; the real problems are production, maintenance of standards, delivery and serving or feeding the patients."

Food Preparation

Miss Owens took over to amplify the matter of food preparation. She stated that food serves a two-fold function in the mental hospital—it contributes to both the physical and emotional rehabilitation of the patient. The role that the kitchen plays in this matter can be based on three major responsibilities: first, the use of accepted scientific methods of cooking and preparation to preserve the initial nutrients; second, to make the meals attractive, palatable and varied; and third, to provide special foods when corrective diets are prescribed.

Miss Owens dispelled the notion that food prepared in large quantities cannot be tasty and appealing, but noted that retaining those qualities in serving presented complex problems.

"It must be remembered," she said, "that quality has a price and that good management along with sufficient equipment and paid personnel, and high quality food supplies, must be provided if desirable food standards are to be maintained."

Several of the methods employed in California institutional kitchens to provide better-tasting foods, such as on-the-spot grilling teams and batch-type cooking, will be printed in greater detail in the Proceedings of the Institute.

Assigning Patients

Miss Owens included in her discussion the assignment of patients to kitchen duty.

"The purpose of placing patients in the kitchen is for work therapy and training," she said. "The selection and assignment of patients is obviously a medical decision; however, once a patient has been assigned to the kitchen for work, it then becomes a kitchen responsibility to see that the patient is well placed in an area where he can be trained to the best of his ability. This will be done in both the interest of good food management and in the therapeutic effect that we want to have."

She goes on to urge that cooks should be encouraged to make ward rounds, and that the doctors, nurses and aides make kitchen rounds, because, as she says, "The kitchen and the food program is one part of the total hospital program; the medical personnel must understand the food problems and the food personnel must also understand the medical problems."

FOOD PROCUREMENT AND STORAGE

Dr. Sleeper's contribution concerned methods of purchasing and storing food supplies. He said the success of any food procurement plan depended on close cooperation between the administrator, the purchasing agent, the storekeeper, accountants, and produce suppliers.

He stressed the importance of a sensibly-planned food budget. "It is all too common to establish food budgets on the basis of the preceding year's expenditure, regardless of needs," he said.

For several years Massachusetts has been developing a ration system computed on scientific nutritional requirements, consideration given to normal eating habits, and the variety and taste-appeal of the menu.

The ration is priced at current market level with extra funds appropriated to accommodate rising costs. This way the basic ration does not have to be cut to meet the budget.

Hospital Farms

Produce from the institutional farm, including canned and frozen foods, can be a real budget aid, if properly managed.

At Augusta State Hospital the farm is considered an independent supply market. The steward has complete authority to evaluate the produce from it. Substandard or over-ripe items are either rejected or marked down.

Other Factors

Dr. Sleeper warned that inadequate receiving and storage facilities affect purchasing procedures. "Spoilage will result and the economy of large-quantity purchasing will be lost," he said.

He pointed out that mass buying by a central agency can save considerable money, particularly if the individual institutions are allowed some leeway to make spot purchases on local "bargains".

Dr. Sleeper mentioned several publications on canned-goods specifications put out by the U. S. Department of Agriculture. He also noted that the Department maintains thirty inspection offices at strategic points around the country which grade samples for a fee. "Bid samples are often requested and should, of course, be tested," he said.

Checking and Accounting

Dr. Sleeper emphasized that all food should be checked at the institution when it is received, particularly perishable goods. The food should be checked again in the kitchen before using. Dr. Sleeper listed the "warning signals" that indicate inferior, even dangerous, foodstuffs.

The goods received should also be checked for accurate weight and count, and immediate requests made for adjustment when warranted. Dr. Sleeper advises the use of duplicate receiving slips. This enables the accounting department to take advantage of cash discounts for immediate payment.

Serving Food

Dr. Chambers concluded the panel with suggestions for assuring that the food is palatable when it reaches the patients. He said that most foods should be served as soon after preparation as possible. Such foods as eggs and toast that lose most of their appeal in standing should be prepared right in the dining room. Portions should be equal, and foods not mixed haphazardly on the plates.

Dr. Chambers stressed particularly the use of small tables to permit each patient to choose his own table companions, and the use of a full set of silverware by all except the few unable to use it properly.

He cited the advantages of cafeteria service for all patients able to cooperate: a choice of foods may be served without difficulty; the patient may sit where he pleases, and he can eat at his own pace. Cafeteria service is also a boon to management; fewer employees and less dining space are needed; cooking and serving can be done simultaneously; second helpings can be easily served. Also, the clean-up problem is lessened in many cafeterias by having the patients carry their trays to the clean-up room. Dr. Chambers continued with suggestions for well-planned dining and clean-up facilities.

INTENSIVE TREATMENT

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Psychiatric Unit, Omaha, Neb., said that caution in a "total push" program was necessary. A total push program might well be more push than therapy unless the psychiatrist guided it carefully.

Staff members should discuss their own attitudes with the superintendent, said other commentators, and face the fact that love and affection cannot be ordered three times a day or as a continuous drip.

Doctor's Final Responsibility

The final responsibility for an intensive treatment program must rest with the superintendent or chief of psychiatric services, though other members of the treatment team played an important part. It was possible to apply intensive treatment by these techniques even if a hospital had little money and was short of personnel.

It was possible for much therapeutic good to reach even the back yards, by means of obscure people. Not only could all personnel be utilized but other patients too. It was a common experience that improved patients often took interest in less accessible patients, to the mutual good of both.

COMMENTARY

Books
Pamphlets
Reports
Periodicals

(Commentary's chief purpose is to call the attention of MHS subscribers to articles, reports, pamphlets, books, or other documents that have been published elsewhere and are of particular interest to mental hospitals. When MHS has copies or reprints on hand for distribution or loan, this fact is noted in the column. For copies of other material, please write directly to the publisher.).

Occupational therapists, especially in smaller hospitals, should see the feature article in the October issue of *Hospitals*, "Planning the Complete Occupational Therapy Service." Written by Wilma L. West, O. T. R. and Alonza W. Clark, A.I.A., the piece outlines the recommendations of the American Occupational Therapy Association.

Architects' plans show typical occupational therapy departments for hospitals up to 250 bed capacity, including a basic plan said to be suitable for psychiatric as well as tuberculosis and general hospitals. Placement of equipment is shown on the floor plans. Equipment and supply lists are appended to the article.

The architect-designed shops were fitted to the requirements of a committee composed of occupational therapists with specialty experience.

The basic plans are for departments in a small hospital, and are presented more as guides for planning similar units than as rigid solutions for all types of occupational therapy departments. MENTAL HOSPITALS adds the suggestion that recreational therapists who include art and handcraft programs in their department might be interested in the supply lists of expendable and non-expendable materials.

Frank Longo, Director of the Recreational Therapy Department of Columbus State School, writes about his program and its aims in the September issue of *Public Welfare in Ohio Today*. Mrs. Dorothy K. Castle, a case worker from Ashtabula, Ohio, in the same issue of the magazine, publishes "Some More Ideas on Recreational Therapy." Mrs. Castle writes about her work in the community, especially among older people—an interesting contrast to Mr. Longo's discussion of the children in his group.

Yet another occupational therapy piece comes from Clifford B. Gloyd, of Harlem Valley State Hospital, in the *N. Y. Mental Hygiene News* for September, reprinted from the June issue of *The Psychiatric Aide*. Mr. Gloyd's title is "On-the-Ward Workshops," and describes assignments to occupational therapy immediately the routine admission is completed. The objective is to get the patient settled and adjusted to hospital routine, until, if not ready for discharge, he may be assigned to the off-ward OT workshop or to a hospital industry.

A book review in the *Digest of Neurology and Psychiatry* upon public education in psychiatry—is it possible or desirable?—states that author Carl Binger, M.D., of the Payne Whitney Psychiatric Clinic, New York, believes that the public should be given some insight into human behavior and relationships. The book should be of interest to the hospital superintendent who is approached by the layman for assistance in newspaper or magazine stories. Public education, says Dr. Binger, is one step in the prevention of psychoneuroses.

"Group Psychotherapy with Psychotics" is the subject of a piece in June's *Journal of Psychiatric Social Work*, written by Dr. Christopher T. Standish and Dr. Elvin V. Semrad, both of Boston State Hospital. The authors comment on the fact that group therapy contributes to the general therapeutic atmosphere of a large state hospital because it is possible to have more patients under treatment. Patients also become more cooperative, they state, and less resistive with attendants. For this reason group therapy facilitates the task of caring for patients. "It is our feeling," say Drs. Standish and Semrad "that one of the chief obstacles to group psychotherapy lies in the therapists themselves." They state that the organization of the group at Boston was accompanied by many misgivings and anxieties.

Of interest to the social service department particularly and to other members of the treatment team concerned directly with the patient is the *VA Technical Bulletin, TB 10A-279*, which deals with family care.

The bulletin describes the procedure followed when patients having a final diagnosis of psychosis, but whose condition has improved, are to be placed on a trial visit in the community in homes other than their own.

The purpose of the program, states the bulletin, is to enable the patient to re-establish himself in the community under the most satisfactory conditions.

It discusses the selection of patients, the selection of homes, financial arrangements, the necessity for chest X-rays and dental care before the patient goes out, and the supervision of patients while on the visit. A full bibliography is given at the end of the bulletin.

The October issue of *The Modern Hospital* has an article by Dr. Theo K. Miller, Superintendent of Napa State Hospital, California, on "Color is Good Medicine for Mental Patients." Dr. Miller describes the pleasing use of color in his new modern 700 bed treatment center now under construction. Of particular interest is his mention of "murals"—landscapes applied like wall paper and coated with lacquer. The effect, says Dr. Miller, is excellent and the execution inexpensive.

AIDE TRAINING

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now working among a total of 1800 attendants in state hospitals. This 15% figure indicates that although the training programs have had little direct impact on the great mass of attendants in that state, the trained technicians furnish an example and a higher percentage of supervisory personnel.

College Credits

Dr. George W. Jackson told of a training program which Texas is sponsoring in cooperation with junior colleges. The trainees receive college credits which can be applied towards a nursing degree if desired. Such interest was shown by the audience in this plan that Dr. Jackson and his colleague on the Texas Board of State Hospitals and Schools, Dr. Hayden H. Donohue, have consented to prepare a full description to be distributed soon to all M.H.S. members.

SEXUAL PSYCHOPATHY

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made that an offender be given a complete psychiatric examination before being sentenced. He would remain in a State psychiatric institution until considered sufficiently cured to return to the community.

The first appearance of what is called sexual deviation can be seen in children at an early age. That is why prevention is the most vital part of any program. Mental hygiene courses in teacher training schools would enable teachers to recognize early symptoms of deviation and direct such a child toward therapy before his difficulties led him into abnormalities in later life.

More study should be given, not only to the offenders themselves, but to their victims, especially when these are children. Inept handling especially by parents may cause several psychological trauma. Counselling for the parents of both offender and victim is indicated. Mental hygiene programs in schools would do much to increase public understanding of the problem.

NEW APA PROJECTS

(Continued from Page 1)

cal, and it was important that psychiatrists should attend general medical meetings such as those of local societies. Several superintendents arose to say that their staff was particularly active in this field.

In reply to a question, Dr. Addison M. Duval, of St. Elizabeths Hospital, Washington, D. C., said it was true that floor plans of new mental hospital buildings would be of great value to members, but that the service was also snowed under with requests for such specific smaller items as the best type of doors for treatment rooms, the kind of screens to use in admission centers, and what was the optimum size of rooms for this purpose or that. In order to have source material for information of this kind, the service needed funds.

It was suggested that the Council for State Governments should be approached with a view to getting a grant for this purpose. Another suggestion was that State Architects' Associations might be willing to finance such an information program since frequently the architect himself had to start from the beginning in trying to meet the requirements peculiar to mental hospital construction.